Editorials

Votes and Dollars in Health Care

IN A PRESIDENTIAL ELECTION YEAR, the political and social processes that make things happen are very much in the news and attract considerable attention. The driving forces of all this activity are votes and dollars. Politicians seeking to gain or retain public office need both in considerable quantities. They seek both wherever they are to be found, in exchange for promises and commitments—real or implied—that they may or may not wish or be able to honor when they actually gain office. Such is our political system. In the private sector some dollars are diverted for what is called political action—that is, to help candidates for political office get the votes to be elected, with the hope that they will then bear in mind the sources of this support in their actions while in office.

What has all this to do with health care? The impact of both dollars and votes has actually proved to be profound. For example, in the public arena the voting power of the elderly far exceeds that of children and youth, who cannot vote at all. And what has happened? Political support for the care of the elderly is substantially greater than for the care of children and youth, especially the needy. In the private sector, where the dollar reigns supreme, health care is increasingly seen as a profitable or potentially profitable business. The profits are derived from "consumers" who are able to pay, and, conversely, there are no profits, only unwanted costs, when those who cannot pay are served.

This has led to a truly anomalous situation where the elderly, even the rich elderly, receive good health care at government expense, while needed government programs for the children and youth upon whom the future of the nation depends are being curtailed for reasons of economy. The elderly live longer at greater and greater health care expense, while evidence accumulates that the health of youth, particularly disadvantaged youth, is being eroded. And in the private sector, 30 to 40 million Americans are said to be uninsured for health care, many because they cannot afford it or are, for some reason, uninsurable. Something is very wrong.

Votes and dollars are powerful forces in a nation with political and economic systems such as ours. This is the way it is. But these systems, stripped to their essentials, are apt to be without much human compassion, and in themselves offer little incentive for looking or planning beyond the next election or the next foreseeable bottom line. Perhaps another force is needed to influence the votes and dollars that are responsible for health care. If so, this force should be a voice of compassion for human need and a voice for the long-term betterment of the human condition within the political and socioeconomic systems where we must operate. It should be a powerful voice. Physicians and the medical profession are well positioned by interest and training to fill this role. They should be addressing those who vote and those who pay—that is, patients and the public. The campaign for a smoke-free society, which seems to be making good progress, could be something of a model for what can and should be done in the interest of health and well-being in this nation.

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Physicians and Smoking Cessation

IN 1984, JESSE STEINFELD, a former Surgeon General of the United States, wrote in this journal: "Physicians as a group have the lowest incidence of cigarette smoking of any profession or occupation. They also have both the opportunity and obligation to their patients and to society to take a far more active role in eliminating our number one health problem."[1] Earlier this year, Malcolm S. M. Watts commented in the journal: "Cigarette smoking is not only in itself a bad practice, but it can also be good practice for physicians to actively encourage their patients to quit and then find ways to help them do it."[2] In this issue, Prochazka and Boyko outline practical methods that physicians can employ to assist patients to give up smoking.

Although patients are aware of the health risks of smoking, they often do not understand the relative importance of smoking as a cause of preventable death in the United States. For example, in a recent Harris survey of the ten most important things to do to protect one's health, the general public ranked not smoking tenth, behind such items as having a smoke detector in the home and obtaining adequate vitamins and minerals. In the same survey, health professionals ranked not smoking first.[3]

Cigarette smokers experience increased total mortality, compared with nonsmokers, because they are at increased risk to die of five of the six leading causes of death in the US, including coronary artery disease, malignant neoplasms, cerebrovascular disease, chronic obstructive pulmonary disease, pneumonia, and influenza.[4,5] Cigarette smoking contributes to the development of atherosclerosis and the acute ischemic and occlusive vascular events seen with coronary artery disease, sudden unexpected death, cerebrovascular disease, arteriosclerotic peripheral vascular disease, and aortic aneurysm. Cigarette smoke contains carcinogens such as polynuclear aromatic hydrocarbons and nitrosamines, which in susceptible smokers produce cancer of the lung, larynx, mouth, esophagus, bladder, kidney, pancreas, stomach, and uterine cervix. Cigarette smoke contains pulmonary irritants that lead to chronic bronchitis. Smoking also appears to create an imbalance between pulmonary proteases and their inhibitors that results in emphysema.[6]

Cigarette smoking exerts an adverse effect on the outcome of pregnancy; spontaneous abortions, stillbirths, perinatal deaths, and low-birth-weight infants are all more likely if a woman smokes during pregnancy. Smoking also appears to produce adverse long-term effects on the physical growth and intellectual skills of children born to women who smoke while pregnant.

Peptic ulcer disease is more likely to occur, less likely to heal, and more likely to cause death in smokers than in nonsmokers. Cigarette smoking increases perioperative morbidity through its adverse effects on the cardiac, pulmonary, immune, and coagulation systems. It also alters the metabolism of commonly prescribed drugs such as theophylline and β-adrenergic blockers and thus may complicate the medical management of several diseases. Other disorders are observed more frequently in smokers than in nonsmokers, such as osteoporosis, periodontal disease, tuberculosis, infertility,

chronic laryngitis, spontaneous pneumothorax, and Buerger's disease. Involuntary smoke inhalation is a cause of lung cancer in healthy nonsmokers. The children of parents who smoke, compared with children whose parents do not, have an increased frequency of respiratory tract infections and symptoms.

Because nonsmokers live longer and have fewer chronic health problems than smokers, efforts should be directed toward helping children and teenagers maintain their nonsmoking status. Promising educational programs teach students to recognize social influences that encourage smoking and to develop behavioral skills to resist these influences.

Epidemiologic studies document that former cigarette smokers have decreased risks of subsequent morbidity and mortality compared with smokers. Hammond's study of 1 million men and women showed that smoking cessation is beneficial for smokers in all age groups.[7] In this study, mortality rates of former cigarette smokers decreased gradually over time. Ten years after quitting, mortality rates of those who smoked less than 20 cigarettes a day were equivalent to those of nonsmokers. The former smokers who had smoked more than 20 cigarettes a day also showed progressive declines in mortality rates over time, but ten years after quitting, their mortality rates were still higher than those of nonsmokers.

Large prospective studies have established that smoking cessation results in a progressive reduction in mortality rates for the tobacco-related diseases. For coronary artery disease, there may be as much as a 50% reduction in the risk of death within the first year after quitting. For lung cancer and chronic obstructive pulmonary disease, the reduction in risk of death occurs more slowly and may not approach the nonsmoker's risk for 20 or more years after quitting. Smoking cessation is most beneficial when initiated early in life. This is especially true for those disorders such as chronic obstructive pulmonary disease in which smoking causes irreversible damage. Patients with chronic bronchitis and emphysema who quit smoking experience a decline in the prevalence of cough, and their rate of decline in lung function slows to approximate that of age-matched nonsmokers. The adverse effects of smoking on the fetus may be avoided if the mother does not smoke during pregnancy. Patients with peptic ulcer disease heal their ulcers more promptly if they quit smoking.

Smoking cessation is important for all smokers, but it is especially important for those with the highest risks. Young persons who are heavy smokers benefit the most from quitting. Those in high-risk categories because of heredity, occupational or environmental exposures, coexisting diseases or risk factors, and drug exposure should receive special attention.

The steady decline in US smoking prevalence continues. In 1985 an estimated 32.7% of adult men and 28.3% of adult women smoked cigarettes on a regular basis. In the same year in the US, there were about 51 million adult smokers and 41 million adult former smokers. An estimated 95% of these former smokers quit without formal assistance.

Cigarette smoking is an addictive behavior and shares several characteristics with drug dependency involving the use of alcohol, cocaine, and heroin. Some of these characteristics include repetitive and compulsive use, tolerance, and the development of a withdrawal syndrome. A minority of persons with addictive behaviors such as cigarette smoking achieve and maintain abstinence with their first attempt; knowledge of this point may help health professionals to have more realistic treatment goals and may help smokers to understand the course leading to cessation.

Physician intervention is effective in assisting patients to stop smoking.[8] Prochazka and Boyko correctly point out, however, that "the great potential for physicians to intervene in the smoking cessation process has not been realized." The practical guidelines proposed by these authors include identifying the smoking habit, providing brief counseling and self-help programs, and following up to help prevent relapse. They also outline a more intensive intervention program that emphasizes a "behavioral smoking cessation plan," the use of nicotine gum in selected patients, and maintaining abstinence. Prochazka and Boyko reviewed the few studies that used nicotine gum combined with brief advice; they concluded that the gum should not be used in this situation. Additional studies are needed before firm judgments can be made on whether nicotine gum should be used in the traditional office setting.

Physicians have the opportunity to assist their smoking patients by functioning as clinical counselors. The first step is to accept cigarette smoking as a chronic medical problem requiring treatment and to note this on the problem list. Thereafter, the patient should receive a personalized message concerning the risks of smoking and a self-help pamphlet on quitting. The treatment program should be individualized because no single method has been found to be superior to any other; the "cold turkey" approach appears to be more effective than the "tapering" approach, however. An understanding of tobacco dependency and the tobacco withdrawal syndrome aids the clinical counselor to anticipate obstacles and to help the patient achieve and maintain abstinence. The patient should be encouraged to set a quit date and should be scheduled for a follow-up appointment with the physician. If a more comprehensive treatment program is required, referral to a smoking cessation specialist should be arranged.

Most physicians are nonsmoking role models. Many physicians are working in societal roles to help achieve a smoke-free environment. Beyond these efforts there is a great need for more patients to receive personalized smoking cessation assistance from their physicians. The National Cancer Institute is supporting five major smoking cessation trials involving physicians and dentists.[9] Residency training programs for the development of smoking intervention skills are also being implemented.[10] Widespread clinician involvement in smoking cessation programs will also depend on third-party reimbursement for clinical counseling. As these training and reimbursement issues are resolved, "the great potential for physicians to intervene in the smoking cessation process" may be realized.

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Euthanasia—The Continuing Debate

THE DEBATE OVER ACTIVE EUTHANASIA again has captured public and professional attention because of the de facto legalization of active voluntary euthanasia in the Netherlands,[1] a drive in the spring of 1988 to place a proposition legalizing euthanasia on the California ballot, and the publication of the case vignette, "It's Over, Debbie," in *The Journal of the American Medical Association (JAMA)*.[2] The lucid and eloquent article by Professor Albert Jonsen elsewhere in this issue is an important contribution to this discussion. Several points in his article deserve elaboration or emphasis.

The Importance of Clear Terminology

The debate over euthanasia is sometimes marred by ambiguous terminology and rhetoric. Several practices in the care of dying patients should be distinguished. "Active euthanasia" is sometimes called direct killing. Euthanasia is called voluntary when a patient requests it.

Active euthanasia is generally distinguished from withholding or withdrawing treatment (also termed "allowing to die" or "passive euthanasia"). As Jonsen explains, in some cases the moral line between withholding treatment and active euthanasia may be difficult to draw. Such difficult cases, however, are exceptions to a general rule of thumb that separates these two practices. Concern that active euthanasia is unethical should not lead physicians to continue futile treatments or to reject requests by competent, informed patients to withhold or withdraw treatment. Prolonging life is not always the appropriate goal of medical care. A medical, ethical, and legal consensus has developed that physicians should respect refusals of treatment by informed, competent patients, even if their lives will be shortened. Furthermore, prior refusals of treatment by incompetent patients should also be respected.[3,4]

Assistance with suicide may be requested by some patients. For example, a man with end-stage acquired immunodeficiency syndrome may believe that living with pain, fatigue, progressive disfigurement, and uncontrolled diarrhea is degrading and may wish to have control over his death. He might ask his physician how to end his life or request medications to do so. Suicide differs from the other actions discussed here because the patient's own actions lead to death. In such patients, a wish to commit suicide might be considered rational because their conditions are irreversible. In contrast, the vast majority of patients who seriously consider suicide have clinical depression that is likely to respond to changes in the psychosocial situation, counseling, or taking antidepressants. Because persons incapacitated by depression cannot make autonomous or informed decisions, physicians have a duty to intervene so that they do not harm themselves.

Many physicians oppose assisted rational suicide for the same reasons that Jonsen opposes active euthanasia. Furthermore, the law in most states prohibits assisted suicide. Some physicians and commentators, however, condone assisted rational suicide, arguing that death results from the patient's actions, rather than from those of the physician.[5]

Another practice is giving doses of analgesics that might hasten death. This practice is discussed next in more detail.

The Importance of Supportive Care

For most patients, a request for active euthanasia may represent a cry for help, a fear of abandonment, a demand for more control over their care, or a way to call attention to physical or emotional pain. In Holland, 85% of patients with terminal illness who request active euthanasia change their minds after they receive better relief of their symptoms (P. Admiraal, MD, written communication, October 30, 1987). Thus, ethical debates over active euthanasia can often be resolved clinically by improving supportive care for a patient. In the United States, 20% of patients with metastatic cancer experience unrelieved severe pain during their last weeks of life.[6] Other dying patients may suffer from severe dyspnea, for instance, from end-stage chronic obstructive lung disease or from *Pneumocystis carinii* pneumonia that has not responded to the use of antibiotics. Even when physicians cannot cure the underlying disease or its complications, they can relieve both physical and emotional suffering and, indeed, have an ethical duty to do so.

In such cases, the physician should give analgesics and sedatives to control symptoms. We have learned a great deal about how to use analgesics effectively[7,8]: The dosage should be gradually increased until symptoms are relieved. Regular doses are more effective than "as needed" dosing. Behavioral, neurosurgical, and anesthetic approaches to pain control need to be considered, and attention to emotional and spiritual pain is essential. Giving patients control over the timing of medications can also be effective. No predetermined dosage limit should be set, since such patients may require much larger doses than are needed for acute pain. Side effects should be anticipated and treated. A patient's response should be carefully monitored.

We also have learned some common errors in managing pain. Doses of analgesics that are prescribed by physicians or administered by nurses may be too low to achieve the desired relief of symptoms. Often doses are restricted because of concerns about addiction, but such concerns should not be paramount in patients who will die in a short time.

In most cases, pain can be relieved without depressing consciousness or respiration. When, however, relief requires doses that cause these side effects, ethical and emotional dilemmas occur. The traditional doctrine of "double effect" justifies using such high doses: The physician intends to control pain, this laudable goal cannot be achieved without also causing the undesirable effects, and it is better to relieve symptoms in patients with terminal illness than to allow them to suffer. It is essential, of course, that lower doses be shown to be ineffective and that the lowest dose that relieves symptoms be used.

The Danger of Abuse

Opponents of active euthanasia commonly raise practical objections. They fear that the potential for abuse is great and that voluntary euthanasia can all too easily lead to involuntary